services for the employer. During this extended period of coverage, the plan charges the employee $100 per month for employee-only coverage and $250 per month for family coverage. (This extended period of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 2*, the plan provision allowing extended coverage for disabled employees and their families satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled employees a higher premium during the extended period of coverage.

Example 3. (i) *Facts.* To comply with the requirements of a COBRA continuation provision, a group health plan generally makes COBRA continuation coverage available for a maximum period of 18 months in connection with a termination of employment but makes the coverage available for a maximum period of 29 months to certain disabled individuals and certain members of the disabled individual's family. Although the plan generally requires payment of 102 percent of the applicable premium for the first 18 months of COBRA continuation coverage, the plan requires payment of 150 percent of the applicable premium for the disabled individual's COBRA continuation coverage during the disability extension if the disabled individual would not be entitled to COBRA continuation coverage but for the disability.

(ii) *Conclusion.* In this *Example 3*, the plan provision allowing extended COBRA continuation coverage for disabled individuals satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled individuals a higher premium for the extended coverage if the individuals would not be eligible for COBRA continuation coverage were it not for the disability. (Similarly, if the plan provided an extended period of coverage for disabled individuals pursuant to State law or plan provision rather than pursuant to a COBRA continuation coverage provision, the plan could likewise charge the disabled individuals a higher premium for the extended coverage.)

(2) *In premiums or contributions*—(i) Nothing in this section prevents a group health plan from charging individuals a premium or contribution that is less than the premium (or contribution) for similarly situated individuals if the lower charge is based on an adverse health factor, such as disability.

(ii) The rules of this paragraph (g)(2) are illustrated by the following example:

Example. (i) *Facts.* Under a group health plan, employees are generally required to pay $50 per month for employee-only coverage and $125 per month for family coverage under the plan. However, employees who are disabled receive coverage (whether employee-only or family coverage) under the plan free of charge.

(ii) *Conclusion.* In this *Example*, the plan provision waiving premium payment for disabled employees is permitted under this paragraph (g)(2) (and thus does not violate this section).

(h) *No effect on other laws.* Compliance with this section is not determinative of compliance with any provision of ERISA (including the COBRA continuation provisions) or any other State or Federal law, such as the Americans with Disabilities Act. Therefore, although the rules of this section would not prohibit a plan from treating one group of similarly situated individuals differently from another (such as providing different benefit packages to current and former employees), other Federal or State laws may require that two separate groups of similarly situated individuals be treated the same for certain purposes (such as making the same benefit package available to COBRA qualified beneficiaries as is made available to active employees). In addition, although this section generally does not impose new disclosure obligations on plans, this section does not affect any other laws, including those that require accurate disclosures and prohibit intentional misrepresentation.

(i) *Applicability dates.* This section applies for plan years beginning on or after July 1, 2007.

[T.D. 9298, 71 FR 75030, Dec. 13, 2006; 72 FR 7929, Feb. 22, 2007, as amended by T.D. 9464, 74 FR 51678, Oct. 7, 2009]

§ 54.9802–2 Special rules for certain church plans.

(a) *Exception for certain church plans*—(1) *Church plans in general.* A church plan described in paragraph (b) of this section is not treated as failing to meet the requirements of section 9802 or § 54.9802–1 solely because the plan requires evidence of good health for coverage of individuals under plan provisions described in paragraph (b)(2) or (3) of this section.

(2) *Health insurance issuers.* See sections 2702 and 2721(b)(1)(B) of the Public Health Service Act (42 U.S.C. 300gg–2 and 300gg–21(b)(1)(B)) and 45 CFR 146.121, which require health insurance issuers providing health insurance coverage under a church plan that is a group health plan to comply with nondiscrimination requirements similar to those that church plans are required to comply with under section 9802 and § 54.9802–1 except that those nondiscrimination requirements do not include an exception for health insurance issuers comparable to the exception for church plans under section 9802(c) and this section.

(b) *Church plans to which this section applies*—(1) *Church plans with certain coverage provisions in effect on July 15, 1997.* This section applies to any church plan (as defined in section 414(e)) for a plan year if, on July 15, 1997 and at all times thereafter before the beginning of the plan year, the plan contains either the provisions described in paragraph (b)(2) of this section or the provisions described in paragraph (b)(3) of this section.

(2) *Plan provisions applicable to individuals employed by employers of 10 or fewer employees and self-employed individuals.* (i) A plan contains the provisions described in this paragraph (b)(2) if it requires evidence of good health of both—

(A) Any employee of an employer of 10 or fewer employees (determined without regard to section 414(e)(3)(C), under which a church or convention or association of churches is treated as the employer); and

(B) Any self-employed individual.

(ii) A plan does not contain the provisions described in this paragraph (b)(2) if the plan contains only one of the provisions described in this paragraph (b)(2). Thus, for example, a plan that requires evidence of good health of any self-employed individual, but not of any employee of an employer with 10 or fewer employees, does not contain the provisions described in this paragraph (b)(2). Moreover, a plan does not contain the provision described in paragraph (b)(2)(i)(A) of this section if the plan requires evidence of good health of any employee of an employer of fewer than 10 (or greater than 10) employees. Thus, for example, a plan does not contain the provision described in paragraph (b)(2)(i)(A) of this section if the plan requires evidence of good health of any employee of an employer with five or fewer employees.

(3) *Plan provisions applicable to individuals who enroll after the first 90 days of initial eligibility.* (i) A plan contains the provisions described in this paragraph (b)(3) if it requires evidence of good health of any individual who enrolls after the first 90 days of initial eligibility under the plan.

(ii) A plan does not contain the provisions described in this paragraph (b)(3) if it provides for a longer (or shorter) period than 90 days. Thus, for example, a plan requiring evidence of good health of any individual who enrolls after the first 120 days of initial eligibility under the plan does not contain the provisions described in this paragraph (b)(3).

(c) *Examples.* The rules of this section are illustrated by the following examples:

Example 1. (i) *Facts.* A church organization maintains two church plans for entities affiliated with the church. One plan is a group health plan that provides health coverage to all employees (including ministers and lay workers) of any affiliated church entity that has more than 10 employees. The other plan is Plan *O*, which is a group health plan that is not funded through insurance coverage and that provides health coverage to any employee (including ministers and lay workers) of any affiliated church entity that has 10 or fewer employees and any self-employed individual affiliated with the church (including a self-employed minister of the church). Plan *O* requires evidence of good health in order for any individual of a church entity that has 10 or fewer employees to be covered and in order for any self-employed individual to be covered. On July 15, 1997 and at all times thereafter before the beginning of the plan year, Plan *O* has contained all the preceding provisions.

(ii) *Conclusion.* In this *Example 1,* because Plan *O* contains the plan provisions described in paragraph (b)(2) of this section and because those provisions were in the plan on July 15, 1997 and at all times thereafter before the beginning of the plan year, Plan *O* will not be treated as failing to meet the requirements of section 9802 or § 54.9802–1 for the plan year solely because the plan requires evidence of good health for coverage of the individuals described in those plan provisions.

Example 2. (i) *Facts.* A church organization maintains Plan *P*, which is a church plan that is not funded through insurance coverage and that is a group health plan providing health coverage to individuals employed by entities affiliated with the church and self-employed individuals affiliated with the church (such as ministers). On July 15, 1997 and at all times thereafter before the beginning of the plan year, Plan *P* has required evidence of good health for coverage of any individual who enrolls after the first 90 days of initial eligibility under the plan.

(ii) *Conclusion.* In this *Example 2,* because Plan P contains the plan provisions described in paragraph (b)(3) of this section and because those provisions were in the plan on July 15, 1997 and at all times thereafter before the beginning of the plan year, Plan *P* will not be treated as failing to meet the requirements of section 9802 or § 54.9802–1 for the plan year solely because the plan requires evidence of good health for coverage of individuals enrolling after the first 90 days of initial eligibility under the plan.

(d) *Applicability date.* This section is applicable to plan years beginning on or after July 1, 2007.

[T.D. 9299, 71 FR 75056, Dec. 13, 2006]

§ 54.9802–3T Additional requirements prohibiting discrimination based on genetic information (temporary).

(a) *Definitions.* Unless otherwise provided, the definitions in this paragraph (a) govern in applying the provisions of this section.

(1) *Collect* means, with respect to information, to request, require, or purchase such information.

(2) *Family member* means, with respect to an individual —

(i) A dependent (as defined for purposes of § 54.9801–2) of the individual; or

(ii) Any other person who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual or of a dependent of the individual. Relatives by affinity (such as by marriage or adoption) are treated the same as relatives by consanguinity (that is, relatives who share a common biological ancestor). In determining the degree of the relationship, relatives by less than full consanguinity (such as half-siblings, who share only one parent) are treated the same as relatives by full consanguinity (such as siblings who share both parents).

(A) First-degree relatives include parents, spouses, siblings, and children.

(B) Second-degree relatives include grandparents, grandchildren, aunts, uncles, nephews, and nieces.

(C) Third-degree relatives include great-grandparents, great-grandchildren, great aunts, great uncles, and first cousins.

(D) Fourth-degree relatives include great-great grandparents, great-great grandchildren, and children of first cousins.

(3) *Genetic information* means—

(i) Subject to paragraphs (a)(3)(ii) and (a)(3)(iii) of this section, with respect to an individual, information about—

(A) The individual's genetic tests (as defined in paragraph (a)(5) of this section);

(B) The genetic tests of family members of the individual;

(C) The manifestation (as defined in paragraph (a)(6) of this section) of a disease or disorder in family members of the individual; or

(D) Any request for, or receipt of, genetic services (as defined in paragraph (a)(4) of this section), or participation in clinical research which includes genetic services, by the individual or any family member of the individual.

(ii) The term *genetic information* does not include information about the sex or age of any individual.

(iii) The term *genetic information* includes—

(A) With respect to a pregnant woman (or a family member of the pregnant woman), genetic information of any fetus carried by the pregnant woman; and

(B) With respect to an individual (or a family member of the individual) who is utilizing an assisted reproductive technology, genetic information of any embryo legally held by the individual or family member.

(4) *Genetic services* means—

(i) A genetic test, as defined in paragraph (a)(5) of this section;

(ii) Genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(iii) Genetic education.

(5)(i) *Genetic test* means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. However, a genetic